Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov

MEDICAID MEMO

Changes in Billing for Medicare “Crossover” Claims

Last Updated: 03/09/2022

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Changes in Billing for Medicare "Crossover" Claims

The Department of Medical Assistance Services (DMAS) is in the process of enhancing our Medicaid Management Information System (MMIS) so that all claims submitted to Medicaid for payment after they have been processed by Medicare are paid correctly and consistent with State and federal guidelines. The principal change being made is to ensure that the Medicaid reimbursement for Medicare claims, in combination with the Medicare payment, does not exceed Medicaid allowed amounts. The modifications to the MMIS will be implemented on December 1, 2003, and for some providers will require changes to the billing procedures for paper Medicare claims postmarked after November 21, 2003. Please read this Memo carefully to ensure that you are aware of how these claims will be paid and that you are prepared for the new procedures.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

In order to collect all of the information needed to calculate the amount Medicaid will pay for Part A and outpatient hospital services, DMAS will begin to require that these services be submitted on a UB-92 claim form when a paper claim form is filed.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible recipients are automatically submitted to DMAS by the Medicare claims processors (fiscal intermediaries and carriers) based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

There are no changes in the process for the automatic submission of Medicare claims from the Medicare fiscal intermediaries. These claims will continue to be submitted on your behalf by the Medicare claims processors and will be priced according to the Medicaid reimbursement rules described in this Memo.

DMAS provides information about dually eligible (Medicaid and Medicare) recipients to the following Medicare fiscal intermediaries and carriers. If you submit your claims to any of the following, your claims should be automatically crossed over to Medicaid.

- United Government Services
- AdminaStar Federal
- Palmetto GBA
- Trailblazer Health Enterprises, Part A
- Trailblazer Health Enterprises, Part B

Please note that this process will work correctly **only** if DMAS has your Medicare vendor number on file. Your Medicare-assigned vendor number is added to our Medicare cross- reference file, which links the Medicare vendor number to your Medicaid provider number when crossover claims are received from the Medicare intermediaries and carriers. If we are unable to associate the Medicare vendor number on the crossover claim with a valid Medicaid provider number, the claim is held and recycled for 180 days until a match is found. If a match cannot be made after 180 days, the claim is denied.

The vendor number on the file maintained by Medicaid that links to the Medicare vendor number in the claims file received from Medicare must be the rendering provider's individual Medicare number. If the Medicare group number is on a claim, it must also be on the cross-reference file. All of the claims for the group will be paid under the single Medicaid provider number associated with the Medicare group number.

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FILING YOUR MEDICARE VENDOR NUMBER WITH VIRGINIA MEDICAID

At the time of enrollment in Medicaid, a provider may not have a Medicare number assigned. If this is the case, save the Request for Title XVIII (Medicare) Information form contained in the enrollment package and mail or fax the form to our fiscal agent's, First Health Services Corporation, Provider Enrollment Unit as soon as a vendor number is assigned by Medicare. The form (which is included as an attachment to this Memo) may be copied for multiple enrollments, and you are requested to submit a form for each provider. The Title XVIII Information form is not a requirement, but its use is encouraged so that all of the required information and signatures are submitted to Medicaid. Please feel free to call the First Health Provider Enrollment Unit at any time to inquire about your Medicare/Medicaid enrollment and to verify that the information we have on file is correct. The Title XVIII form may also be printed from the Virginia Medicaid website at http://virginia.fhsc.com (do not enter www as part of the web address).

To contact the First Health Provider Enrollment Unit (PEU) you may call:

1-888-829-5373 (In-State) 1-804-270-5105 (Out-of-State)

Or, you may fax the Request for Title XVIII (Medicare) Information form to: 1-804-270-7027

Or, you may send your Request for Title XVIII (Medicare) Information form to:

First Health Services
Corporation Provider
Enrollment Unit

PO Box 26803

Richmond, VA 23261-6803

SUBMITTING PAPER MEDICARE CLAIMS

If an electronic Medicare claim is not automatically crossed over to Medicaid, a provider can submit a paper claim. Claims for services previously billed to Medicare should be submitted using paper claims only under the following conditions:

- You submitted your Medicare claim to a Medicare fiscal intermediary or carrier other than those listed above. Please encourage your Medicare intermediary or carrier to contact First Health's Provider Enrollment Unit (PEU) to inquire about setting up automatic crossovers with Virginia Medicaid.
- You are re-filing a previously denied claim or adjusting a previously paid claim.
- You have contacted First Health's Provider Enrollment Unit and requested that your Medicare provider number be removed from the Medicare cross-reference file.
- You have not received notification that your claim has crossed over, and it has been more than 60 days since you received your Explanation of Medicare Benefits (EOMB).

DMAS utilizes several methods to research the exact reason that claims identified on your Medicare EOMB as "Crossed to Medicaid" may not appear on your Medicaid Remittance Advice. If you are experiencing this type of difficulty, please call First Health's Provider Enrollment Unit (in Virginia call 1-888-829-5373; out of Virginia call 1-804-270-5105) so that your specific problem can be researched before you resort to submitting a paper claim.

******Important Billing Form Changes******

To correctly calculate reimbursement for Medicare Part A and outpatient hospital claims, DMAS will begin requiring that paper claims for Part A and outpatient hospital services be submitted on a UB-92 claim form rather than the DMAS-30 Title XVIII Claim form currently used. Paper claims submitted to Medicaid for Medicare Part A and outpatient hospital services must be on the paper UB-92 form beginning for claims postmarked after November 21, 2003. **Any claims for Part A or outpatient hospital services postmarked after November 21, 2003 that are on the DMAS-30 Title XVIII Claim form will be returned, regardless of the date of service.** If you are unable to submit your Part A and outpatient hospital Medicare claims on the UB-92 by the above date, we ask that you hold your claims until they can be submitted on the correct form.

Billing instructions for using the UB-92 form to submit Medicare claims are attached. These instructions will be incorporated into the Medicaid Billing Manuals and posted to our website at a future date. Please use the attached instructions to begin submitting Part A and outpatient hospital paper claims beginning with claims postmarked after November 21, 2003, regardless of the dates of service.

Medicare Part B paper claims will continue to be submitted using the DMAS-30 Title XVIII Claim form, except for outpatient hospital services. Please note that the DMAS-30 Title XVIII Claim form should be sent as a claim, not as an attachment to a CMS-1500 claim. Sending it as an attachment will result in the CMS-1500 claim being denied with a message to bill Medicare first.

In the future, the DMAS-30 Title XVIII Claim form will be modified to reflect that it no longer is to be used for Part A claims. However, the current form can continue to be used for Medicare Part B services (other than outpatient hospital). DMAS–30 Title XVIII Claim forms can be obtained by calling the DMAS Order Desk at 804-780-0076 or faxing your order to 804-780- 0198. Note that DMAS does not supply UB-92 claim forms.

PAYING MEDICARE CLAIMS

As mentioned previously, Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it was billed directly to Medicaid. In the event that the Medicare reimbursement equaled or exceeded the Medicaid reimbursement rate, your claim will be denied with reason 0364 (Primary carrier payment equals or exceeds DMAS' allowed amount).

In order to correctly process and reimburse Medicare claims, the Medicaid claims processing system must calculate the Medicaid allowed amount for the services

identified on the claim. With few exceptions, a Medicare claim will be considered invalid if it does not contain the data needed to calculate the Medicaid allowed amount. These claims and the errors detected will be identified on your paper and/or electronic (835/U277) remittance.

It is understood that Medicare claims from Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) do not conform to normal Medicaid billing practices, in that Medicare claims are based on revenue code and Medicaid claims on procedure code. However, the Medicaid allowed amount for these facilities is equal to the Medicare allowed amount. So for Medicare claims from FQHCs and RHCs, the Medicaid allowed amount will be set to the Medicare allowed amount. Any claims for services not covered by Medicaid will be paid based on the coinsurance and deductible amounts submitted.

AUTOMATIC MEDICARE CROSSOVER PROBLEMS

DMAS has recently discovered that some dually eligible recipients are not being included in the eligibility files being sent to the Medicare fiscal intermediaries and carriers. This is resulting in claims not being automatically crossed over that should be, necessitating paper claims to be submitted. DMAS is working on a resolution to this problem, and we will have it resolved when the December eligibility files are created.

As stated previously, when crossover claims are processed by Medicaid, we need to match the Medicare vendor number to a valid Medicaid provider number. A Medicare vendor number can only be associated with one Medicaid provider number. For the crossover process to work correctly, the Medicare vendor number on the Medicare claim **must** be associated with the correct Medicaid provider number. If you are unsure whether your vendor number is known by DMAS, or if it is associated with the correct Medicaid provider number, please contact First Health's Provider Enrollment Unit (PEU) at the numbers listed above.

SUMMARY OF CHANGES

DMAS' MMIS is being enhanced effective December 1, 2003 to ensure that, whenever possible, claims that were previously processed by Medicare will be adjudicated so that the amount paid by Medicaid, in combination with the Medicare payment, will not exceed the amount Medicaid would pay for the service if it was billed directly to Medicaid. In general, Medicare claims will be expected to contain the information needed by the Medicaid system to apply its pricing rules. In the few cases where this cannot be done (i.e., claims for non-covered services), claims will be reimbursed using the submitted deductible and coinsurance amounts.

Most Medicare claims are automatically crossed over to Medicaid by a Medicare fiscal intermediary or carrier. If you are having problems with claims crossing over, or if you need to register your Medicare vendor number with Medicaid, please contact the First Health Provider Enrollment Unit.

If you need to submit a Medicare claim on paper, Medicare Part A and outpatient hospital claims must be on the UB-92 form beginning with claims postmarked after November 21 2003, regardless of date of service. Part B claims (other than outpatient hospital services) will continue to be submitted on the DMAS-30 Title XVIII Claim form.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its provider manuals and Medicaid Memoranda on the DMAS website at www.dmas.state.va.us. Refer to the Provider Column to find Medicaid and SLH provider manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273
Richmond area
1-800-552-8627
All other areas

Please remember that the "HELPLINE" is for provider use only.